



State of Utah  
Department of Workforce Services  
**REVIEW/RECERTIFICATION**

PLEASE USE A BLACK BALL  
POINT PEN TO COMPLETE  
FORM

PID#: \_\_\_\_\_

**YOUR CERTIFICATION PERIOD IS ENDING!** Your eligibility needs to be redetermined. Failure to complete and return this review form will result in a delay, reduction or termination of your \_\_\_\_\_ assistance. Complete this form and return it to the local Department of Workforce Services by the \_\_\_\_\_ day of \_\_\_\_\_. You may call \_\_\_\_\_ for help with this form.

Please provide your name and address below.

Name: \_\_\_\_\_ Return this form to: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Mailing Address: \_\_\_\_\_

Street

City

State

Zip

Phone #: \_\_\_\_\_

**If you need help with this recertification form, tell us. A DWS Representative will help you. You have the right to turn in this recertification form today by providing only your name, address, and sign the back page of the form.**

**COMPLETE YOUR REVIEW ON TIME**

If you receive Financial, Medical, Child Care or Food Stamps assistance your case will close at the end of the review month if you do not complete your review. An interview may be required. Completing your review includes providing verifications requested by your worker. You will be notified what verifications are needed.

**GOOD CAUSE FOR A LATE REVIEW**

If you have a good reason for not completing your review forms on time, please contact your worker at the Department of Workforce Services. Your worker will let you know if completing your review late is approved. If not approved to be late, your case will be closed.

**FOLLOW THESE EASY STEPS**

1. Return these forms and all requested verifications to your local office. If you only receive Food Stamps, you do not need to answer the questions marked with an asterisk (\*). Your worker may request more verifications from you after reviewing your case. You must always verify your income.
2. An interview may be required. If you have someone who is authorized to represent you, they may complete the interview for you. If you need an interpreter, please tell us and we will make arrangements to help you.
3. We encourage you to take or mail these forms to your local office. If an appointment is needed, your worker will schedule an interview. It is your responsibility to reschedule a missed interview. A return envelope is enclosed if you choose to mail your review.
4. If you receive Food Stamps and everyone in your household receives SSI you may turn in your review forms and be interviewed at the local Social Security office.

**VOTER REGISTRATION INFORMATION**

- If you are not registered to vote where you live now, would you like to register to vote here today? . . . . . ☐ Yes ☐ No
  - If you mark yes, you will receive a Voter Registration form.
- Voter registration does not affect the amount of assistance you may receive.
- If you would like help filling out the voter registration form, we will help you. The decision to seek or accept help is yours. You may fill out the registration form in private.
- If you believe someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor of the State of Utah, 203 State Capitol Building, SLC, UT 84114.



Starting with yourself, please list everyone who is receiving **benefits with you**:

Name	Social Security #	Birth Date and Age	U.S. Citizen Yes/No	Relationship	Student Yes/No	Ethnicity *see below	Race **see below	Sex	Marital Status
				Self					

\*Ethnicity

H = Hispanic or Latino

N = Not Hispanic or Latino

\*\*Race

AI = American Indian or Alaska Native

AS = Asian

BL = Black or African American

PI = Native Hawaiian or

other Pacific Islander

WH = White

**What is the Primary Language Spoken in your Household?** \_\_\_\_\_

\*1. Is anyone in your home pregnant? (Medical proof of pregnancy will be required).....☐ Yes ☐ No

Name:		Expected Date of Birth:	
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2. Are you interested in receiving information about adoption assistance? .....☐ Yes ☐ No

3. Do you eat with everyone in your home? (List below anyone who doesn't) .....☐ Yes ☐ No

Name:	
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4. Is anyone in your household living in one of these institutions? .....☐ Yes ☐ No

☐ Hospital

☐ Shelter

☐ Drug/Rehab Center

☐ Boarding School

☐ Group Home

☐ Nursing Home

☐ Jail-if yes, on work release?

Name:		Name of Institution:	
Admission Date:		Release Date:	

5. Is anyone 16 or older unable to work because of physical or mental problems?.....☐ Yes ☐ No

Name:		Date Unable to Work?		When able to Work?	
Medical Problem (a medical verification may be required):					

6. Do you have an authorized representative? .....☐ Yes ☐ No

If you want to choose an adult to help you with your Food Stamps, Medical Card and Check give us that person's name, address and telephone number below. This person will then be your **Authorized Representative**.

Name:		Phone #:		Relationship:	
Address:					

Street

City

State

Zip

7. Has anyone sold, traded, or given away anything in the last 3 months? ..... ☐ Yes ☐ No  
If yes, please explain: \_\_\_\_\_

8. A. Are you a fleeing felon?..... ☐ Yes ☐ No B. Are you violating your probation or parole? ..... ☐ Yes ☐ No

9. Does anyone (including children) have any of the items listed below? ..... ☐ Yes ☐ No  
DOES ANYONE HAVE THEIR NAME ON AN ACCOUNT BELONGING TO SOMEONE ELSE? ..... ☐ Yes ☐ No

No

☐ SaVings Account  
☐ Credit Union Acct  
☐ Time Certificates  
☐ IRA/KEOGH/401K

☐ Personal Checking Account  
☐ Money Market Certificates  
☐ STocks/Bonds  
☐ Personal Needs Account

☐ Trust Fund (TF/TM/TR)  
☐ CAsh  
☐ Other: \_\_\_\_\_

Name of Financial Institution	Account #	Joint? Yes/No	Type of Acct	Owner/Joint Owners	Amount	Ver	F I A C

10. Does anyone own or is anyone buying any of the types of vehicles listed below, or does anyone have their name on a vehicle belonging to someone else? ..... ☐ Yes ☐ No

☐ CAr ☐ SnowMobile ☐ MotorCycle ☐ Other Vehicle (dune buggy, etc.)  
☐ Truck/Van ☐ Motor Home ☐ BoaTs/Motors ☐ ATV, etc.

Type of Vehicle	Make	Year/ Model	Licensed Yes/No	State and License #	Owner/Joint Owners	Use	Current Value	Amount Owed	Ver	V E H I

11. Does anyone own, or is anyone buying, any of the types of property listed below? ..... ☐ Yes ☐ No  
INCLUDE PROPERTY CO-OWNED WITH SOMEONE NOT LIVING WITH YOU.

☐ HOme you live in (Exempt) ☐ Camper/TRailer(CP/TR) ☐ LiFe Insurance (LF/LI)  
☐ Other Homes ☐ Notes or Contracts (NC/NO) ☐ Funeral Plan/Burial Contract  
☐ Time Share Condos ☐ Satellite Dish ☐ Burial Plans/Cemetery Plots (BS/BC)  
☐ Rental Property ☐ Livestock/Horses (LC/LX) ☐ Life Estates/Life Leases  
☐ Land/Mineral Rights ☐ Tools/Equipment/Inventory  
☐ Oil or Gas Leases ☐ Other: \_\_\_\_\_

Type of Property	Owner/Joint Owners	Joint? Yes/No	Current Face/Market Value	Current Equity/Cas h Value	Ver	O T A S

12. Has anyone in your home applied for or is anyone now receiving educational benefits? ..... ☐ Yes ☐ No
- ☐ Scholarships (**BI/OF/ON**)                      ☐ V.A. Educational Benefits  
☐ Other Educational Grants and Loans (**OD/OE/OF/ON**)                      ☐ PELL/BEOG  
☐ SEOG    ☐ SSIG (**ST**)  
☐ NDSL    ☐ Other (I.E. family, work study, church, employer, etc.)

School Name: _____	School Name: _____	U N I E
Amount of Benefits: _____	Amount of Benefits: _____	
Time Periods Covered: _____	Time Periods Covered: _____	
Educational Expenses: (tuition, books, fees) _____	Educational Expenses: (tuition, books, fees) _____	
Expected Graduation Date: _____	Expected Graduation Date: _____	
Circle One:    Full-time    Part-time    Less than part-time	Circle One:    Full-time    Part-time    Less than part-time	

13. Has anyone applied for or is anyone now receiving any of these types of UNEARNED INCOME? ..... ☐ Yes ☐ No
- ☐ Social Security                      ☐ Unemployment Insurance (**UC**)  
☐ Church Assistance (**CC/IK**)                      ☐ Railroad Retirement                      ☐ Civil Service Annuity  
☐ SSI    ☐ Workman's Compensation                      ☐ Inheritances, Settlements, Etc.  
☐ Child Support                      ☐ Veteran's Benefits                      ☐ Cash Gifts (**CC**)  
☐ Alimony    ☐ Lump Sum Payments                      ☐ Pension (**CV/RT**)  
☐ Other \_\_\_\_\_

Are any deductions being withheld from these benefits? (child support taxes, health insurance, overpayments, etc.)  
 Explain: \_\_\_\_\_ ☐ Yes ☐ No

Name	Type of Unearned Income - Claim #	Denied ? Yes/No	Amount		Date Applied /Received	Date Benefits Will Begin	U N I N
			\$	per			
			\$	per			
			\$	per			

14. Has anyone in your household changed jobs or stopped working in the last 4 months? ..... ☐ Yes ☐ No
- For Food Stamp recipients, has anyone in your household changed jobs or stopped working in the last 30 days? ..... ☐ Yes ☐ No

Name:		Name of Employer & Phone #:		Date Left Job:		V O Q S
Date Last Check Received:		Reason for Leaving:				
Date Expect To Return To Work:		Is It A Temporary Layoff?				

## 15. A. Employment information - YOU WILL BE ASKED TO VERIFY THIS INCOME.

NAME					NAME				
Is this a temporary job?		If yes, how long will it last?		What is your hourly wage?	Is this a temporary job?		If yes, how long will it last?		What is your hourly wage?
How often Paid? (Circle one): 2X monthly      Every 2 weeks Monthly      Weekly      Daily      Hourly      Other					How often Paid? (Circle one): 2X monthly      Every 2 weeks Monthly      Weekly      Daily      Hourly      Other				
Name of Employer (Employer may be contacted), Address and Phone Number					Name of Employer (Employer may be contacted), Address and Phone Number				
Date Started		Average Hours Worked per Week		Day of Month/Wk Paid	Date Started		Average Hours Worked per Week		Day of Month/Wk Paid
Date Paid Day/Mo/Yr	Hours Worked	Gross	Tips	Actual/ Best Est.	Date Paid Day/Mo/Yr	Hours Worked	Gross	Tips	Actual/ Best Est.

B. Are any deductions being withheld from this income?  
(child support taxes, health insurance, overpayments, etc.) ..... ☐ Yes ☐ No  
If yes, explain: \_\_\_\_\_ (You will be required to verify)

16. Is anyone in the household SELF - EMPLOYED? ..... ☐ Yes ☐ No  
If yes, list the Annual Income: \$ \_\_\_\_\_ Annual Expenses: \$ \_\_\_\_\_  
**(You will be required to verify the income and expenses or you can choose 40% for expenses.)**

17. Do you pay for dependent care so you can go to work, look for work, or get training? ..... ☐ Yes ☐ No

Name of Dependent	Amount Paid Each Month (Attach Receipts)	Who Pays?	Provider Name \ Relationship

**Failure to report and verify any of the above listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.**

18. Do you expect any CHANGES in your circumstances? ..... ☐ Yes ☐ No  
If yes, check those that apply and explain: \_\_\_\_\_

- |                                    |   |  |   |
|------------------------------------|---|--|---|
| <input type="checkbox"/> Earnings  | <input type="checkbox"/> Dependent care | <input type="checkbox"/> Income              | <input type="checkbox"/> Number of Hours Worked |
| <input type="checkbox"/> Resources | <input type="checkbox"/> Expenses       | <input type="checkbox"/> Living Arrangements | <input type="checkbox"/> Other                  |

19. Are you legally obligated to pay child support to a non-household member? ..... ☐ Yes ☐ No  
 If you are paying, how much? ..... You will be required to verify.

\*20. If you receive medical assistance, put a check mark in front of any of these expenses paid by anyone in the household.

- ☐ Tools ☐ Uniforms, Special Clothing (EE) ☐ Mandatory Union Dues  
☐ Retirement (MR) ☐ Other

\*21. Insurance Information

Check the appropriate box	Insurance Information
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does anyone in your household currently have health insurance (including VA Health Care System benefits), or: - Have insurance available but not enrolled - Had insurance in the past 6 months <b>If yes, please complete the chart below. (Do not list Medicaid, Medicare, CHIP or PCN)</b>
<input type="checkbox"/> Enrolled	Name of insurance company: _____ Phone #: _____ Address of insurance company: _____ Group #: _____ Policyholder name: _____ Policy #: _____ Policyholder date of birth: _____ Policyholder SS #: _____ If insurance is through an employer, list employer name and phone#: _____ Premium: \$ _____ Date due: _____ How often? _____ Name of individuals covered (If not listed on the insurance card): _____
<input type="checkbox"/> Not enrolled, but available  <input type="checkbox"/> Ended, Date ended _____	Name of insurance company: _____ Phone #: _____ Address of insurance company: _____ Group #: _____ Policyholder name: _____ Policy #: _____ Policyholder date of birth: _____ Policyholder SS #: _____ If insurance is through an employer, list employer name and phone#: _____ Premium: \$ _____ Date due: _____ How often? _____ Name of individuals covered (If not listed on the insurance card): _____
<b>Major Medical Need Information:</b>	
Does someone in your home have a major medical need?* <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, who? _____ *Pregnancy is considered a major medical need.	
Check the type of incident	<b>Accident, Assault, or Other Liability:</b> If any household members have been injured in an accident, assault, or someone outside your household is required to pay for medical services, complete this section.
<input type="checkbox"/> automobile <input type="checkbox"/> dog bite <input type="checkbox"/> assault <input type="checkbox"/> slip/fall <input type="checkbox"/> work-related <input type="checkbox"/> other* <input type="checkbox"/> medical malpractice	Name of household member: _____ Who is responsible? _____ Date of Incident: _____ Police department: _____ Police report #: _____ Name of attorney: _____ Phone #: _____ *Explain other: _____

\*22. If you are receiving/applying for Medicaid, is child support or alimony paid by someone in your home who is a spouse or parent of a disabled person (if yes, provide receipt)? ..... ☐ Yes ☐ No

\*23. If you are receiving/applying for Medicaid, are there Children of a disabled adult or siblings of a disabled person in your home? ..... ☐ Yes ☐ No  
 If yes, do these non-disabled people have income? ..... ☐ Yes ☐ No  
 (Please declare and verify this income in question #15, #16).

24. Please check the boxes in front of each expense you pay. These are expenses for which you are responsible.

Expense	Current Amount	Past Due Amount	How Often Billed?	Who is responsible for payment?	Who pays the bill?	Ver	S H E X
<input type="checkbox"/> Rent							
<input type="checkbox"/> Mortgage							
<input type="checkbox"/> Second Mortgage							
<input type="checkbox"/> Trailer Space Lot Payment							
<input type="checkbox"/> Homeless Shelter Costs							
<input type="checkbox"/> Property Taxes (If <b>NOT</b> incl. in mortgage)							
<input type="checkbox"/> Insurance on Home (If <b>NOT</b> incl. in mortgage)							

**Failure to report and verify any of the above listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.**Page 7

25. Is your rent government subsidized? .....☐ Yes ☐ No If yes, what is the amount YOU pay? \$ \_\_\_\_\_  
Agency's name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Amount agency pays: \_\_\_\_\_

26. If you are applying/recertifying for Food Stamp benefits, do you have a heating or cooling expense separate from your rent or mortgage costs? .....☐ Yes ☐ No  
A. How is your home heated? (gas, electric, etc.,)  
B. How is your home cooled?  
C. I received HEAT/LIHEAP assistance at my current residence in the last year? .....☐ Yes ☐ No

27.

Which children need child care?	Why do you need child care? (Check all items appropriate for your family.)					For worker to complete: Is there an approved activity for child care assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Employment Full-time	Employment Part-time	Self-Employment	Education/ Training	Other: What?	

28. Do you have a credit balance with your child care provider? .....☐ Yes ☐ No  
If yes, how much? \$ \_\_\_\_\_

Customer Signature	Date	Authorized Food Stamp Representative (Print)
		<input type="checkbox"/> Approved <input type="checkbox"/> Closure Code: _____
Spouse of The Customer or Witness Signature (Spouse's signature not required for Food Stamps)	Date	FF. <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date: _____
If the applicant CANNOT write or sign name above, a mark (X) will be used instead of a signature. One witness is required to verify and witness the applicant's mark; use Spouse Section above.		Signature of Worker Date